SERFF Tracking Number:	*SELX-125819276*	*State:*	*Arkansas*
Filing Company:	*SENTRY LIFE INSURANCE COMPANY*	*State Tracking Number:*	*40235*
Company Tracking Number:	*GMLAR0153804F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Multiple Lines*		
Project Name/Number:	*Multiple Lines/GMLAR0153804F01*		

Filing at a Glance

Company: SENTRY LIFE INSURANCE COMPANY

Product Name: Multiple Lines	SERFF Tr Num: SELX-125819276	State: ArkansasLH
TOI: H21 Health - Other	SERFF Status: Closed	State Tr Num: 40235
Sub-TOI: H21.000 Health - Other	Co Tr Num: GMLAR0153804F01	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: SPI SentryInsuranceLH	Disposition Date: 09/19/2008
	Date Submitted: 09/16/2008	Disposition Status: Approved-Closed

Implementation Date Requested: 01/01/2009

Implementation Date:

State Filing Description:

General Information

Project Name: Multiple Lines	Status of Filing in Domicile: Authorized
Project Number: GMLAR0153804F01	Date Approved in Domicile: 08/28/2008
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 09/19/2008	
State Status Changed: 09/19/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

SENTRY LIFE INSURANCE COMPANY

NAIC # 169-68810

FEIN # 39-6040276

785-501-40 GROUP INSURANCE - EMPLOYER APPLICATION

COMPANY FILING # MULTIGMLAR0153804F01

SERFF Tracking Number:	*SELX-125819276*	*State:*	*Arkansas*
Filing Company:	*SENTRY LIFE INSURANCE COMPANY*	*State Tracking Number:*	*40235*
Company Tracking Number:	*GMLAR0153804F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Multiple Lines*		
Project Name/Number:	*Multiple Lines/GMLAR0153804F01*		

The above referenced form is included for your review.

This new form will be used with our group insurance products currently on file with your department.

We trust with the enclosed information you will be able to review our filing and grant an approval. If you have any questions, please contact us.

Thank you in advance for your help and attention to this matter.

Company and Contact

Filing Contact Information

Linda Pawlowski, Compliance/Development Sr. Analyst
1800 North Point Drive
Stevens Point, WI 54481

Linda.Pawlowski@sentry.com
(715) 346-6028 [Phone]
(715) 346-6044[FAX]

Filing Company Information

SENTRY LIFE INSURANCE COMPANY
1800 North Point Drive
Stevens Point, WI 54481
(715) 346-6000 ext. [Phone]

CoCode: 68810
Group Code: 169
Group Name:
FEIN Number: 39-6040276

State of Domicile: Wisconsin
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$60.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
SENTRY LIFE INSURANCE COMPANY	$60.00	09/16/2008	22537162

SERFF Tracking Number:	*SELX-125819276*	*State:*	*Arkansas*
Filing Company:	*SENTRY LIFE INSURANCE COMPANY*	*State Tracking Number:*	*40235*
Company Tracking Number:	*GMLAR0153804F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Multiple Lines*		
Project Name/Number:	*Multiple Lines/GMLAR0153804F01*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/19/2008	09/19/2008

SERFF Tracking Number:	*SELX-125819276*	*State:*	*Arkansas*
Filing Company:	*SENTRY LIFE INSURANCE COMPANY*	*State Tracking Number:*	*40235*
Company Tracking Number:	*GMLAR0153804F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Multiple Lines*		
Project Name/Number:	*Multiple Lines/GMLAR0153804F01*		

Disposition

Disposition Date: 09/19/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SELX-125819276*	*State:*	*Arkansas*
Filing Company:	*SENTRY LIFE INSURANCE COMPANY*	*State Tracking Number:*	*40235*
Company Tracking Number:	*GMLAR0153804F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Multiple Lines*		
Project Name/Number:	*Multiple Lines/GMLAR0153804F01*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOC, AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Group Insurance - Employer Application	Approved-Closed	Yes

SERFF Tracking Number:	*SELX-125819276*	*State:*	*Arkansas*
Filing Company:	*SENTRY LIFE INSURANCE COMPANY*	*State Tracking Number:*	*40235*
Company Tracking Number:	*GMLAR0153804F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Multiple Lines*		
Project Name/Number:	*Multiple Lines/GMLAR0153804F01*		

Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	785-501-42	Application/ Enrollment Form	Group Insurance - Employer Application	Initial		41	785-501-42.PDF

GROUP INSURANCE - EMPLOYER APPLICATION

1800 North Point Drive
P.O. Box 8024
Stevens Point, WI 54481
1(800) 648-1122

SENTRY® LIFE INSURANCE COMPANY

Section 1: EMPLOYER INFORMATION

1) Legal Name of Business ABC Company — Telephone Number (123) 456-7890
(DBA name if applicable) _____

123 Main Street	Any Town	Any County	Any State	12345
Business Address • Number and Street	City	County	State	Zip Code

Fax Number _____ Email Contact: _____

2) Nature of Business Manufacturing SIC Code 123 Years in Business 15
Federal Employer Identification Number 12-1234567

3) Ownership Type: ☐ Sole Proprietor ☐ Partnership ☒ Corporation ☐ Other _____

Please complete the following information for any affiliates, subsidiaries or branches that are to be included under this coverage.

Legal Name of Subsidiary Locations	Business Address	Nature of Business - SIC Code

4) Is this insurance replacing another Group Policy? ☐ Yes ☒ No If Yes, what insurance? _____
Date existing group insurance is to be discontinued: ____ (MM) / ____ (DD) / ____ (YY)

5) Have you previously had, or do you now have, insurance with Sentry? ☐ Yes ☒ No
☐ Life ☐ Short Term Disability ☐ Dental ☐ Long Term Disability ☐ Other _____

Section 2: ELIGIBILITY REQUIREMENTS

Eligible employees (including owners, partners and officers) are defined as those full-time employees who currently work 30 or more hours per week, at or from the business premises of the employer or designated worksite. Retirees are not considered eligible employees. If dependent coverage is requested, dependent children will be covered from: Dental - birth to age 19, to age 25 if full-time student. Dependent Life - 14 days to age 19.

6a) A full-time employee currently working in a participating class is eligible:
☒ on the employer's effective date ☐ the first day of the month next following ____ month(s) of employment

6b) An employee hired after the effective date is eligible on the first day of the month next following:
☐ the date of full-time employment ☒ 1 month(s) of full-time employment

7) List all classes of employees to be excluded from this insurance: None

8) Total number of employees: 15 b. Number of eligible employees: 15 c. Number of participating employees: 15

9) For those eligible employees who are not participating, indicate the reason: _____

10) Have you employed 20 or more employees for 20 or more weeks in this or the preceding calendar year?
☐ Yes ☒ No

11) Currently, or in the past 12 months, have you, or any employees been disabled or off work because of illness or injury for 5 or more consecutive days? ☐ Yes ☒ No
If Yes, give name of person, date and duration of disability, nature of disability, and name of insurance carrier at time of disability.

_____

_____

Requested effective date 9 / 1 / 2008

Section 3: BENEFIT SELECTION

Options of Dependent Life, Orthodontia and Salary Definition when selected apply to employees in all classes as described below.
***Denotes option availability is limited by group size.**

☒ **Dependents Life*** Spouse: 10% of employee basic amount Child(ren): 5% of employee basic amount

☒ **Orthodontia Option*** - 50% Co-insurance and $1,500 Lifetime Maximum per person

Salary Definition ☐ **Standard (with commissions no Overtime or Bonus)** ☒ **W-2 Salary**

Class 1

Indicate class description here: Management & Administration

☒ **Life** ☐ Flat Benefit (Minimum $10,000) $ _____ ☐ Reducing Benefit Life $ _____
☐ 1 times **or** ☒ 2 times Salary to a Maximum Benefit of $ 100,000.00

☒ **Short Term Disability**
☐ 50%* **or** ☒ 60% of covered payroll to a Maximum Benefit of $ 1,000
Maximum Benefit Period: ☐ 13 week* ☒ 26 week ☐ 52 week*
Elimination Period: ☐ 0 day accident/7-day sickness ☒ 7-day accident/7-day sickness

☐ **Long-Term Disability**
☐ 50%* **or** ☐ 60% of covered payroll to a Maximum Monthly Benefit of $ _____
Maximum Benefit Period _____ Elimination Period _____
401(k) Contribution Benefit ☐ Yes _____ % ☐ No

☒ **Dental**
Calendar Year Deductible: ☐ $0* ☐ $50 ☒ $100
Calendar Year Maximum: ☐ $500 ☒ $1000 ☐ $2000
Coinsurance: ☒ Option A: 80% preventive/80% Basic/50% Major ☐ Option B: 100% preventive/80% Basic/50% Major

Class 2

Indicate class description here: Production Workers

☒ **Life** ☒ Flat Benefit (Minimum $10,000) $ 20,000 ☐ Reducing Benefit Life $ _____
☐ 1 times **or** ☐ 2 times Salary to a Maximum Benefit of $ _____

☒ **Short Term Disability**
☐ 50%* **or** ☒ 60% of covered payroll to a Maximum Benefit of $ 1,000
Maximum Benefit Period: ☐ 13 week* ☒ 26 week ☐ 52 week*
Elimination Period: ☐ 0 day accident/7-day sickness ☒ 7-day accident/7-day sickness

☐ **Long-Term Disability**
☐ 50%* **or** ☐ 60% of covered payroll to a Maximum Monthly Benefit of $ _____
Maximum Benefit Period _____ Elimination Period _____
401(k) Contribution Benefit ☐ Yes _____ % ☐ No

☒ **Dental**
Calendar Year Deductible: ☐ $0* ☐ $50 ☒ $100
Calendar Year Maximum: ☐ $500 ☒ $1000 ☐ $2000
Coinsurance: ☒ Option A: 80% preventive/80% Basic/50% Major ☐ Option B: 100% preventive/80% Basic/50% Major

Class 3

Indicate class description here: _____

☐ **Life** ☐ Flat Benefit (Minimum $10,000) $ _____ ☐ Reducing Benefit Life $ _____
☐ 1 times **or** ☐ 2 times Salary to a Maximum Benefit of $ _____

☐ **Short Term Disability**
☐ 50%* **or** ☐ 60% of covered payroll to a Maximum Benefit of $ _____
Maximum Benefit Period: ☐ 13 week* ☐ 26 week ☐ 52 week*
Elimination Period: ☐ 0 day accident/7-day sickness ☐ 7-day accident/7-day sickness

☐ **Long-Term Disability**
☐ 50%* **or** ☐ 60% of covered payroll to a Maximum Monthly Benefit of $ _____
Maximum Benefit Period _____ Elimination Period _____
401(k) Contribution Benefit` ☐ Yes _____ % ☐ No

☐ **Dental**
Calendar Year Deductible: ☐ $0* ☐ $50 ☐ $100
Calendar Year Maximum: ☐ $500 ☐ $1000 ☐ $2000
Coinsurance: ☐ Option A: 80% preventive/80% Basic/50% Major ☐ Option B: 100% preventive/80% Basic/50% Major

Section 4: CONTRIBUTIONS & PARTICIPATION

12) What percentage of the Employee premium will the Employer pay?
Life 75 % Short-Term Disability 75 % Dental 75 % Long-Term Disability _____ %

13) It is understood that this employer group will not be insured or renewed coverage unless the following requirements are met:

A. On groups with **3-9** employees:

Life and Short-Term Disability • Employers must contribute 100% of insurance premium and all eligible employees must participate.

Dental • Employers must contribute at least 50% of insurance premium and 75% of all eligible employees must participate.

B. On groups of **10+**, the Employer must contribute at least 25% of insurance premiums for each coverage (i.e. Life, STD, LTD, Dental).

Participation requirements are:

Life, Short-Term Disability & Long-Term Disability - 75% of all eligible employees must participate.

Dental • on groups of **10-24** employees - 60% of all eligible employees must participate.
on groups of **25** or more employees - 50% of all eligible employees must participate.

C. **IF THE EMPLOYER PAYS 100% OF THE PREMIUM FOR ANY BENEFIT, 100% OF ALL ELIGIBLE EMPLOYEES MUST PARTICIPATE FOR THAT BENEFIT.**

Section 5: GENERAL REPRESENTATIONS & AGREEMENTS

IMPORTANT - - READ BEFORE SIGNING

I understand that this insurance is subject to the approval of Sentry Life Insurance Company, and that nothing contained herein shall be binding upon said Company until this insurance is approved and accepted by Sentry. I hereby represent that all the information herein, relative to this application and agreement, is true and complete and that I have read and understand the form.

I understand that Sentry will rely on these statements and this information in approving this application and in determining if the enrolling employees may become insured.

Upon Sentry's approval, insurance will become effective on the date specified by Sentry.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

John Doe	President	8-7-08	ABC @Company.com
Authorized Signature	Title	Date	Business e-mail address

Mark M. Sentry	123-456-2222	123	333-4444
Salesperson	Salescode	(Area Code)	Telephone Number

123 1st Street	Any Town	Any State	12345
Salesperson Address	City	State	Zip

Deposit to be credited toward premium upon Sentry's acceptance of this application: $100.00
(Make check payable to Sentry Insurance Company)

For office use only

Account Mastered ☐ Yes ☐ No Date Received ___/___/___

Group # _____ Account # _____

Effective Date _____ Initial _____ Date _____

SERFF Tracking Number:	*SELX-125819276*	*State:*	*Arkansas*
Filing Company:	*SENTRY LIFE INSURANCE COMPANY*	*State Tracking Number:*	*40235*
Company Tracking Number:	*GMLAR0153804F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Multiple Lines*		
Project Name/Number:	*Multiple Lines/GMLAR0153804F01*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SELX-125819276*	*State:*	*Arkansas*
Filing Company:	*SENTRY LIFE INSURANCE COMPANY*	*State Tracking Number:*	*40235*
Company Tracking Number:	*GMLAR0153804F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Multiple Lines*		
Project Name/Number:	*Multiple Lines/GMLAR0153804F01*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice — Approved-Closed — 09/19/2008

Comments:

Attachment:

AR - READABILITY CERTIFICATION.PDF

Review Status:

Satisfied -Name: AR - NAIC TRANSMITTAL DOC, AR - NAIC FORM FILING ATTACHMENT — Approved-Closed — 09/19/2008

Comments:

Attachments:

AR - NAIC TRANSMITTAL DOC.PDF

AR - NAIC FORM FILING ATTACHMENT.PDF

Review Status:

Bypassed -Name: Application — Approved-Closed — 09/19/2008

Bypass Reason: The form being submitted with this filing is a new application and is attached to the Form Schedule. Thank you.

Comments:

Review Status:

Bypassed -Name: Health - Actuarial Justification — Approved-Closed — 09/19/2008

Bypass Reason: This item does not apply to this form-only filing. Thank you.

Comments:

Review Status:

Bypassed -Name: Outline of Coverage — Approved-Closed — 09/19/2008

Bypass Reason: This item does not apply to this filing. Thank you.

Comments:

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: **SENTRY LIFE INSURANCE COMPANY**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
785-501-42	41.1

Signed: William O'Reilly

Name: William O'Reilly

Title: Secretary

Date: September 16, 2008

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	**Prepared for the State of**	Arkansas

2.	**Department Use Only**
	State Tracking ID

3.	**Insurer Name & Address**	**Domicile**	**Insurer License Type**	**NAIC Group #**	**NAIC #**	**FEIN #**	**State #**
	SENTRY LIFE INSURANCE COMPANY 1800 North Point Drive Stevens Point WI 54481	WI		169	68810	39-6040276	

4.	**Contact Name & Address**	**Telephone #**	**Fax #**	**E-mail Address**
	Linda L. Pawlowski, ACS 1800 North Point Drive Stevens Point WI 54481	800-648-1122	715-346-6044	Linda.Pawlowski@sentry.com

5.	**Requested Filing Mode**	☒ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	**Company Tracking Number**	GMLAR0153804F01
7.	☒ **New Submission** ☐ **Resubmission**	Previous file # _____
8.	**Market**	☐ Individual ☐ Franchise Group: ☐ Small ☐ Large ☒ Small and Large ☒ Employer ☐ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____
9.	**Type of Insurance**	H21 Health - Other
10.	**Product Coding Matrix Filing Code**	H21.000 Health - Other
11.	**Submitted Documents**	☒ **FORMS** ☐ Policy ☐ Outline of Coverage ☐ Certificate ☒ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other: _____ ☐ **RATES** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreement ☐ Statement of Variability ☐ Certifications ☐ Actuarial Memorandum ☐ Other: _____

12.	**Filing Submission Date**	September 16, 2008
13.	**Filing Fee (If required)**	Amount $60 sent EFT Check Date _____ Retaliatory ☐ Yes ☒ No Check Number _____
14.	**Date of Domiciliary Approval**	August 28, 2008
15.	**Filing Description:**	

SENTRY LIFE INSURANCE COMPANY

NAIC # 169-68810

FEIN # 39-6040276

785-501-40 GROUP INSURANCE - EMPLOYER APPLICATION

COMPANY FILING # MULTIGMLAR0153804F01

The above referenced form is included for your review.

This new form will be used with our group insurance products currently on file with your department.

We trust with the enclosed information you will be able to review our filing and grant an approval. If you have any questions, please contact us.

Thank you in advance for your help and attention to this matter.

16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Linda L. Pawlowski, ACS Title Compliance/Development Sr. Analyst

Signature Linda L. Pawlowski Date September 16, 2008

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	GMLAR0153804F01
This filing corresponds to rate filing company tracking number	

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
01	Group Insurance - Employer Application	785-501-42	☒ Initial ☐ Revised ☐ Other _____	
02			☐ Initial ☐ Revised ☐ Other _____	
03			☐ Initial ☐ Revised ☐ Other _____	
04			☐ Initial ☐ Revised ☐ Other _____	
05			☐ Initial ☐ Revised ☐ Other _____	
06			☐ Initial ☐ Revised ☐ Other _____	
07			☐ Initial ☐ Revised ☐ Other _____	
08			☐ Initial ☐ Revised ☐ Other _____	
09			☐ Initial ☐ Revised ☐ Other _____	
10			☐ Initial ☐ Revised ☐ Other _____	
11			☐ Initial ☐ Revised ☐ Other _____	